UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK
----------X
ANDRE MULLIN and GABRIEL QUIROS

Petitioners,

-against-

CITY OF NEW YORK, THE NEW YORK CITY POLICE DEPARTMENT, and P.O. "JOHN" ISCOVICI badge # 26836.

Respondents.
----------X

RESPONSE TO DEFENDANTS' FIRST SET OF REQUEST FOR PRODUCTION OF DOCUMENTS

DOCKET #: 07 CV 4760

Plaintiffs, by and through their attorneys, THE LAW OFFICE OF SHABAN KOLECI, Respond to Defendants; First set of Request for Production of Documents as follows:

1. Please see Plaintiffs' Response to Defendants' First Set of Interrogatories.

2. This item is objected to as improper. Please be advised that the items requested in this demand are within the exclusive possession of the defendants, their agents, servants, and/or employees. Moreover, those items requested in this demand are a matter of public record, and this demand is rejected as such. However, without waiving this objection, please be advised that at the present time plaintiffs are not in possession of any documents regarding plaintiffs' arrest with the exception of those items previously forwarded by defense counsel to plaintiffs' attorneys.

3. Please be advised that this item is rejected as overbroad in time and scope. However, without waiving this objection, please be advised that both plaintiffs were treated at St. Vincent's Hospital, located at 355 Bard Avenue, Staten Island, N.Y., immediately following the incidents complained of herein. Attached hereto please find be advised authorizations to receive plaintiffs medical records from said provider.

4. Please be advised that color copies of six (6) photographs depicting injuries received by

Gabriel Quiros as a result of the incident that is the subject of this litigation, as well as color copies of five (5) photographs depicting injuries received by Andre Mullin as a result of the incident that is the subject of this litigation were previously forwarded to your office on or about August 16, 2007. Please be advised that defendants, their agents, servants, and/or employees are within the exclusive possession of additional photographs taken of plaintiffs at the time of the occurrence alleged herein.

5. Please see item number 1 and number 3 above.

6. Please be advised that to date, no subpoenas have been served on party, or any individual entity concerning this litigation.

7. See item number 6 above.

8. Please see item number 1 above.

9. Please be advised that you are not entitled to tax returns.

10. At the present time, plaintiffs have not designated experts to testify at the time of trial. Upon designation, a response pursuant to the FRCP will be provided.

11. Please be advised that this item is objected to as improper and is rejected as over-broad. However, without waiving this objection, please see item number 3 above.

12. Please be advised that this item is objected to as improper and is rejected as over-broad.

13. Please be advised that this item is objected to as improper and is rejected as over-broad. However, without waiving this objection, please find authorizations from the following employers:

GABRIEL QUIROS
Eger Nursing and Rehabilitation Center
140 Miesner Ave.

Staten, Island, NY
February 2005- To date

14. This item is objected to as improper, and over-broad. Additionally, please be advised that you are not entitled to unemployment records. However, without waiving this objection, please be advised neither plaintiff has been a recipient of unemployment benefits

15. This item is objected to as improper, and rejected as vague, and over-broad in scope and time.

16. Please be advised that neither plaintiff has received social security disability benefits.

17. Please be advised that this item is rejected and objected to as over-broad. However without waiving this objection plaintiff Andre Mullin has not been a recipient of Medicare or Medicaid benefits. Additionally, plaintiff Gabriel Quiros was not a recipient of Medicare or Medicaid benefits at the time of the occurrence alleged herein. Furthermore, and without waiving said objection, an authorization to receive records from Medicaid/Medicare from Gabriel Quiros will be forwarded under a separate cover.

Dated:
February 20, 2008

Yours Etc.
STEVEN W. EPSTEIN, ESQ.
Of Counsel To:
LAW OFFICE OF SHABAN KOLECI
Mailing Address:
STEVEN W. EPSTEIN, ESQ.
P.O. Box 929
New York, N.Y. 10040
Office Address: 1 Whitehall Street, 17th floor
New York, N.Y. 10004

TO:
Corporation Counsel
Attn: Jennifer Rubin, Esq.
100 Church Street, Room 3-178
New York, N.Y. 10007

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

OCA Official Form No.: 960

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Mullin, Andre	1/17/78	079-62-4175
Patient Address: 41 Stanley Avenue, Staten Island, NY 10301		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: St. Vincents Hospital 355 Bay St, Staten Island, NY
8. Name and address of person(s) or category of person to whom this information will be sent:* Corporation Counsel 100 Church Street, Rm 3-176 NY, NY 10007
9(a). Specific information to be released:
   - ☐ Medical Record from (insert date) _____ to (insert date) _____
   - ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
   - ☐ Other: _____

Include: (*Indicate by Initialing*)
- _____ **Alcohol/Drug Treatment**
- _____ **Mental Health Information**
- _____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here: _____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
    - ☑ At request of individual
    - ☐ Other:
11. Date or event on which this authorization will expire: 12/31/08
12. If not the patient, name of person signing form:
13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Andrie Mullin
Signature of patient or representative authorized by law.

Date: 2-17-08

STEVEN W EPSTEIN
Notary Public, State of New York
No. 02EP5051592
Qualified in New York County
Commission Expires November 6, 2009

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

2/17/08

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

OCA Official Form No.: 960

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
QUIROS, GABRIEL	10/24/77	100-62-4062

Patient Address: 90 LOCKMAN AVE, STATEN ISLAND, NEW YORK 10303

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
ST. VINCENT'S HOSPITAL 355 BAY AVENUE, STATEN ISLAND, NY

8. Name and address of person(s) or category of person to whom this information will be sent:*
CORPORATION COUNSEL 100 CHURCH ST, Rm-3-178, NEW YORK 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) 6/1/06 to (insert date) TO DATE
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider) to discuss my health information with my attorney, or a governmental agency, listed here: _____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
- ☑ At request of individual
- ☐ Other:

11. Date or event on which this authorization will expire:
6/6/08

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Gabriel Quiros
Signature of patient or representative authorized by law.

Date: 06/06/07

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

Sworn to before me this 6th day of June, 2007

SHABAN KOLECI
Notary Public, State Of New York
No. 01KO5060778
Qualified in Richmond County
Comm. Expires May 20, 2010

AUTHORIZATION TO RELEASE RECORDS

TO:

Eger Nursing and Rehabilitation Center
140 Miesner Ave.
Staten, Island, NY

FROM:
Corporation Counsel
100 Church Street, Room 3-178
New York, N.Y. 10007

RE: **QUIROS, GABRIEL**
D.O.B.-10/24/77
SS# 100-62-4062
February 2005-To date

	MEDICAL TREATMENT RECORDS		MEDICAL NARRATIVE REPORT
	WORKER'S COMPENSATION FILE		NO-FAULT FILE
	RESULTS OF DIAGNOSTIC TESTS	X	WAGE AND ATTENDANCE RECORDS
	DUPLICATE COPIES OF DIAGNOSTIC TEST FILMS		CERTIFIED BILL

Gabriel Quiros (L.S.)

STATE OF NEW YORK, COUNTY OF Richmond ss:

On 2/19/08, before me personally came and appeared GABRIEL QUIROS to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that (s)he executed the same.

Shaban Koleci
NOTARY PUBLIC

SHABAN KOLECI
Notary Public, State Of New York
No. 01KO5060778
Qualified in Richmond County
Comm. Expires May 20, 2010

STEVEN W. EPSTEIN, ESQ.

STATE OF NEW YORK)
ss.:
COUNTY OF NEW YORK)

YUKARI NAKANO, being duly sworn, deposes and says:

I am not a party to this action, am over 18 years of age, and reside at 1 Whitehall Street, 17th floor New York New York. 10004 That on February 21, 2008 I served the within RESPONSE TO DEFENDANTS' FIRST SET OF REQUEST FOR PRODUCTION OF DOCUMENTS upon each of the following attorneys at the address(es) designated by said attorney(s) for that purpose by depositing a true copy of same enclosed in a properly addressed wrapper in an official depository under the exclusive care and custody of the United States Post Office Department within the State of New York:

To:

TO:
MICHAEL A. CARDOZO
Corporation Counsel of the City of New York
Attn: Jennifer Rubin
Attorney for Defendants
100 Church Street, Room 3-178
New York, N.Y. 10007

YUKARI NAKANO

Sworn to before me on
2/22 2008

STEVEN W. EPSTEIN
Notary Public, State of New York
No. 02EP5051592
Qualified in New York County
Commission Expires November 6, 199

NOTARY PUBLIC

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK Docket # 07-CV-4760

ANDRE MULLIN and GABRIEL QUIROS

Petitioners

-against-

CITY OF NEW YORK, THE NEW YORK CITY POLICE DEPARTMENT, and P.O. "JOHN" ISCOVICI badge # 26836.

Respondent(s)

RESPONSE TO DEFENDANTS' FIRST SET OF REQUEST FOR PRODUCTION OF DOCUMENTS

STEVEN W. EPSTEIN, ESQ.
OF COUNSEL TO
LAW OFFICE OF SHABAN KOLECI
ATTORNEY FOR PLAINTIFFS
Office: 1 Whitehall Street, 17th Floor
New York, New York, 10004
Mailing Address: **P.O. BOX 929**
NEW YORK, NEW YORK 10022
(212) 422-2110

To:

Service of a copy of the within is hereby admitted.

Dated,

Attorney(s) for defendant(s)